MEDICARE IS ....
BUT IS NOT ....

A Physician's Guide

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MEDICARE IS . . . BUT IS NOT . . .

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Preface

The Health Care Financing Administration of the Department of Health, Education and Welfare is responsible to the Congress for the administration of Medicare, Medicaid, Professional Service Review Organizations, Survey and Certification of Medical Facilities and detection of fraud and abuse in the above programs.

Through provision of medical services to low income people eligible for Medicaid and the elderly and disabled who qualify for Medicare, physicians relate to these programs and have a need to understand what the program services cover and the reimbursement policies governing each of them.

Medicare IS . . . but is NOT is the first of three booklets which we will issue to introduce new physicians to the programs of the Health Care Financing Administration. In this booklet we attempt to provide the new physician with a concise, orderly introduction to Medicare in the hope it will be of assistance when serving patients covered by the Medicare program. Establishing a medical practice is at best a frustrating experience, especially when the new demands of businessman, personnel director and insurance broker are added to the basic role of medical provider.

We sincerely hope that, as a new physician, you will find this booklet useful in your future dealings with Medicare. I will welcome any suggestions you may have for improving the HCFA programs.

Virginia M. Smyth
Regional Administrator
Health Care Financing Administration

Foreword

On July 30, 1965, in a small auditorium of the Harry S. Truman Memorial Library in Independence, Missouri, Medicare was signed into law. Former President Truman and 200 prominent citizens attended the ceremony. President Johnson, before signing the bill, honored President Truman as the first Chief Executive to initiate health insurance for the elderly.

Medicare was not a new idea in 1965. Government-sponsored health insurance protection had its political roots in the Great Depression. Franklin D. Roosevelt considered including a health insurance program for the poor and elderly in his New Deal legislation. He, however, for tactical reasons chose to set aside the health insurance issue until the rest of his New Deal legislation had been accepted by Congress.

Medicare did not surface again as a subject of political debate until the close of World War II. After the Japanese surrender, President Truman on two occasions endorsed Medicare legislation, but Congress did not follow his recommendations.

The word "Medicare" was first coined in 1960 when Senator John F. Kennedy made it a widely debated issue in his Presidential campaign. Soon after his inauguration, the young President introduced his version of Medicare to Congress. In July 1961, the Ways and Means Committee, chaired by Rep. Wilbur Mills, began hearings on the proposal. To the President's dismay, his Medicare legislation failed to be voted out of committee.

President Johnson's spectacular election victory in 1964 proved to be a harbinger that Medicare's time had come. On March 25, 1965, a new Medicare bill sponsored by Rep. Wilbur Mills passed the House of Representatives without amendment, 313-115. On July 9, the Senate passed the measure by a 68 to 21 vote. On July 27-28, the final bill was approved after a Senate-House conference committee had ironed out 513 differences between the two chambers! On July 1, 1966, the Medicare program finally came into operation.

Since its inception, Medicare has influenced the lives of many Americans both young and old. Today Medicare directly aids 25 million people, approximately 11 percent of our country's population. Unfortunately, many illusions have developed through the years among physicians and patients about the methodology and reimbursement policies of Medicare.

With this pamphlet, the Regional Medicare Bureau hopes to dispel some of the confusion about Medicare that often ensnarls new physicians. We have tried to "infect" our explanation of Medicare with as little government parlance as possible.

We sincerely hope this information will help doctors serve their patients with even greater dedication.

Chapter 1

MEDICARE IS A PROGRAM OF GOVERNMENT-SPONSORED HEALTH INSURANCE FOR THE AGED AND DISABLED BUT IT IS NOT COMMERCIAL INSURANCE, MEDICAID, OR BLUE CROSS/BLUE SHIELD.

Congress passed Medicare as an amendment to the Social Security Act of 1935. Social Security was designed as an insurance program to help people replace a portion of the income lost when they retire or become disabled to work. The Social Security Administration in its annual report to Congress in 1952 identified the high cost of medical care as the greatest single economic affliction of the elderly. Medicare was thus enacted to help fulfill the primary mission of the Social Security program.

Just as Social Security was never meant to be a national pension program, so also Medicare was never conceived to be a mini-national health insurance program. Medicare was not originally designed to cover all the medical expenses of the elderly.

Congress has, however, passed numerous amendments to the Medicare statute since 1965 to allow coverage of new medical services. Medicare has thus matured into a program covering most medically necessary services that your elderly or disabled patients will receive.

Medicare is a two-part program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B). Hospital insurance (Part A) helps pay for medically necessary inpatient hospital care and, after a hospital stay, for inpatient care in a skilled nursing facility and for

care at home by a home health agency. Part A is financed through Social Security taxes and is a compulsory program in that all qualified Social Security beneficiaries are automatically enrolled.

Supplemental Medical Insurance (Part B) is a voluntary program covering most physician care, outpatient hospital treatment, and other medical services and supplies. Part B of Medicare is financed through a monthly premium from each beneficiary (i.e. your patient) with a matching amount paid by the Government from general tax revenues (i.e. the rest of us).[1]

Medicare and Medicaid are two distinct, separate programs. The basic difference between the two is that Medicare is a federally-funded **insurance** program for people 65 or older, disabled people who have received Social Security benefits for at least two years, and people with chronic renal disease—rich or poor.

Medicaid is an **assistance** program for low-income people only, that is financed and administered jointly by the Federal Government and the States.

[1]The Medicare premium, now $8.20 per month, is determined by the Secretary of Health, Education and Welfare each year.

From the beginning, both parts of Medicare have been administered through contracts with private insurance firms. These insurance firms are responsible for the day-to-day claims operations necessary to process over 131 million claims each year.

Organizations that process claims for hospitals, skilled nursing facilities and home health agencies are called **intermediaries.** Organizations processing claims for doctors and other suppliers of services covered under Part B of Medicare are called **carriers.**

As a physician you will be dealing primarily with Part B carriers. (Each carrier in the Southeast is listed in Appendix C.)

Chapter 2

MEDICARE IS GOVERNMENT FUNDED, PRIVATELY ADMINISTERED, BUT IT IS NOT A SOURCE OF PROFIT FOR THE MEDICARE CARRIER OR INTERMEDIARY.

The Medicare Bureau of the Health Care Financing Administration (HCFA), in Baltimore, controls the "purse strings" of the Medicare program. The Medicare Bureau also implements amendments to the Medicare Act that are passed by Congress, interprets regulations formulated by the Secretary of HEW and makes national policy decisions.

Each carrier and intermediary contract with the Medicare Bureau to process claims on a cost only basis. No carrier or intermediary receives more than the actual cost of processing each claim.

The Medicare Bureau has ten regional offices located in major cities throughout the country. Every three months the Regional Offices monitor and review the budget expenditures and projected expenses of each carrier and intermediary. The Regional Offices also annually evaluate the overall performance of each carrier and intermediary and see that the terms of their respective contracts are met.

Contracts with carriers and intermediaries are generally for a term of one year. Contracts are automatically renewable each year unless strong evidence exists to show that a carrier or intermediary's performance is poor or that the terms of the contract have been violated.

Private insurance firms, therefore, do not directly profit from processing Medicare claims. They do not act independently of the Medicare Bureau. When Medicare claims must be reduced or denied, it is done to conform with the law and regulations, not for personal or economic reasons.

Chapter 3

MEDICARE IS A PROGRAM THAT WILL PAY FOR MOST SERVICES YOUR PATIENT WILL RECEIVE IN A LENGTHY HOSPITAL STAY, BUT IT IS NOT A PROGRAM THAT WILL PAY INPATIENT HOSPITAL EXPENSES IN FULL.

Medicare hospital insurance (Part A) will pay the lion's share of inpatient hospital expenses. Part A can help pay for your patient's hospital stay as long as his or her medical condition requires inpatient hospital care.[2] The amount Medicare can pay for a hospital stay is determined by your patient's benefit period. What is a benefit period? A benefit period is a way of measuring your patient's use of services under Medicare hospital insurance. Your patient's first benefit period begins the first time he or she enters a hospital after his or her hospital insurance begins.

When your patient has been out of a hospital or other facility primarily providing skilled nursing or rehabilitative services for 60 days in a row, a new benefit period can start. The number of benefit periods your patient can have is unlimited.

In each benefit period, your patient is responsible for a certain amount of inpatient hospital charges before Medicare can start to pay. The amount the patient is responsible for is called the inpatient hospital deductible and is equivalent to the average cost (nationally) of 1 day of hospital care.

[2]See Appendix A for a listing of covered Part A Services.

From the first day through the 60th day in each benefit period, hospital insurance will pay for all covered services except the first $160.[3] This is called the hospital insurance deductible.

From the 61st through the 90th day in a benefit period, hospital insurance pays for all covered services except $40 a day.[3] The patient's $40 share of the cost is called hospital coinsurance.

If your patient needs more than 90 days of inpatient hospital care in a benefit period, he or she has available 60 lifetime reserve days. Hospital insurance will pay for all covered services except for $80 a day for each reserve day your patient uses.[3] Once your patient uses a reserve day he or she will never get it back. Reserve days are not renewable like the 90 hospital days in each benefit period.

The major benefit of the lifetime reserve provision is to give added protection to patients with long-term illnesses. Some people who are continually institutionalized may have only one benefit period in their lifetime.

Maybe this example will help clarify things.

Jack is hospitalized for 112 days in a benefit period. For how much of the bill would he be responsible?

The answer is $3,120. The deductible ($160) plus coinsurance (30 days x $40) plus the reserve days (22 days x $80).

[3]The Hospital deductible, coinsurance and reserve day amounts are determined by the Secretary of HEW each year. The amounts used in this chapter, therefore, apply only during 1979.

Medicare hospital insurance can also help pay for inpatient care in a participating skilled nursing facility after your patient has been in a hospital. In some facilities, only certain sections participate in Medicare. If you are unsure of whether a facility or a particular section of one participates in Medicare, you should contact the facility or the local Social Security office.

What is the rationale for this section of the law? It is to permit patients who are well enough to move from a high-cost hospital bed to a lower cost skilled nursing facility, thus making hospital beds available to patients who are more acutely ill.

Hospital insurance can help pay for nursing care **only** if the following five conditions are met:

1) Your patient has been in a hospital for at least 3 days in a row before his or her transfer to a participating skilled nursing facility.
2) Your patient is transferred to the skilled nursing facility for a condition treated in the hospital.
3) Your patient is admitted to the facility within 14 days after leaving the hospital.
4) You certify that the patient needs skilled nursing or skilled rehabilitation services on a daily basis.
5) A Professional Standard Review Organization (PSRO) or Utilization Review Committee does not disapprove your patient's stay.[4]

[4]To help Medicare decide whether inpatient care is reasonable and necessary, two types of organizations have been formed—Professional Standard Review Organizations (PSRO's) and Utilization Review Committee (URC's). In most areas of the country, Professional Standard Review Organizations made up of local doctors review the cases of their peers. In those areas where a PSRO is not operative, the skilled nursing facility has a Utilization Review Committee made up of at least two doctors to evaluate the medical necessity of inpatient stays.

The important thing to remember is that your patient must require skilled nursing services to qualify for Medicare coverage. Custodial care (i.e. care provided to meet the personal needs of your patient, for example help in walking, bathing, dressing, eating, etc.) is not considered skilled nursing service. When a patient's stay in a skilled nursing facility is covered, Medicare hospital insurance can pay for up to 100 days of care in each benefit period. The first 20 days of the benefit period Medicare will pay in full. The last 80 days (i.e. the 21st-100th day) in a benefit period Medicare will pay for all covered services except for $20 a day.

Part A Medicare can also pay for medical services rendered by a home health agency. A home health agency is a public or private agency which specializes in providing skilled nursing services and other therapeutic services such as physical therapy in the patient's home.

Medicare can cover medically necessary skilled nursing services furnished by a certified home health agency after the patient has been discharged from a hospital or skilled nursing facility. Part-time skilled nursing care to avoid an inpatient hospital stay is also covered. Each home health service your patient receives is counted in visits. Hospital insurance can pay for up to 100 home health visits each year. Again, remember—if a patient primarily needs custodial care, Medicare also cannot pay for home health services. In fact, Medicare cannot pay for home health services unless you certify that they are medically necessary **and** set up a detailed home health plan.

Chapter 4

MEDICARE IS A HEALTH INSURANCE PROGRAM COVERING MOST PHYSICIAN SERVICES AND MOST PHYSICIAN-ORDERED DURABLE MEDICAL EQUIPMENT, BUT IT IS NOT A PROGRAM COVERING PRESCRIPTION DRUGS, CONVENIENCE ITEMS AND, MOST IMPORTANTLY, MEDICALLY UNNECESSARY SERVICES.

Part B, popularly known as the "doctor's part" of Medicare, covers primarily, physician's services, outpatient hospital services and physical therapy. Medically necessary diagnostic laboratory services performed in a physician's office are always covered. Diagnostic laboratory tests performed in an independent clinical laboratory are covered if the laboratory meets HEW standards. Durable medical equipment like wheelchairs, home dialysis systems and oxygen equipment can also be covered. Part B, however, does **not** cover prescription drugs, eyeglasses, dental care, hearing aids and various other services.[5]

The term "medical necessity" has appeared frequently in our discussion thus far. Why? Because medical necessity is one of the most important and widely misunderstood concepts in the Medicare program. Medical necessity is, in fact, the cornerstone upon which the integrity of Medicare rests. Medicare cannot operate effectively unless physicians use responsible restraint in providing services to their Medicare patients.

[5]For a more complete listing of covered and noncovered services, see Appendix B.

Reimbursement under both Part A and Part B Medicare can be made only for medically necessary covered items and services. Even though Medicare covers most physician's services, claims are often denied because the carrier's staff (which includes physician consultants) cannot identify the medical necessity for a given service.

You, the practicing physician, are in the best position to determine medical necessity. When a physician can say, "I'm rendering this service because my patient wants it, not because he or she needs it," the Medicare carrier will usually reach a similar conclusion and deny the claim. This means that occasionally you will have to inform your patient that a particular service is not medically necessary and that he or she will have to pay the bill without the help of Medicare.

Since most Part B services involve diagnosis and treatment for illness or injury, the carrier can usually assume medical necessity by inspecting your itemized bill. In some instances, you will need to certify medical necessity. For example, when your patient enters a skilled nursing facility, you will need to certify in writing the medical necessity for such services. If your patient requires outpatient physical therapy or speech pathology services, emergency ambulance services, home health agency care, or durable medical equipment, you will also need to certify medical necessity.

Chapter 5

MEDICARE IS A PROGRAM THAT PAYS FOR PHYSICIAN SERVICES ON A "REASONABLE CHARGE" BASIS, BUT IT IS NOT AN INSURANCE PROGRAM THAT PAYS IN FULL. IN FACT ,THE TERM "REASONABLE CHARGE" IS A MISNOMER.

Why didn't Congress make the Medicare program pay for physician's services in full?

Congress considered just such an idea in 1966. Its members, however, concluded that if Medicare paid physician services in full, the program would become enormously expensive and difficult to finance. The Congress also feared that in doing so the Medicare program would cause the health care costs of the rest of the American public to soar.

With these considerations in mind, the "reasonable charge" concept was introduced into the Medicare law. The Part B carrier in each state determines the reasonable charge for each service a physician provides. The methods and procedures used by the carrier in determining reasonable charges must, however, agree with Medicare law, regulations and the policy guidelines set by the Medicare Bureau.

Medicare cannot pay for covered physicians and suppliers services until after the patient has incurred $60 of reasonable charges each year. The first $60 is the Part B deductible. Medicare pays 80 percent of the "reasonable charge" for covered services after the deductible has been met.[6] The patient is responsible for the remaining 20 percent.

[6]Inpatient hospital radiology/pathology services made by a physician are paid at 100 percent of the reasonable charge even if the patient's Part B deductible has not been met.

The reasonable charge for a physician's or a supplier's service is the lowest of three kinds of charges—the actual charge, the customary charge and the prevailing charge.

* The actual charge is the amount that the physician or supplier billed for his service.

* The customary charge is the amount that the physician or supplier most often bills his patients for the same service.[7]

* The prevailing charge is the lowest charge high enough to include at least three-fourths of the bills for the same service made by all the physicians or suppliers in the same area.

The lowest of these three charges is called the "reasonable charge." For instance, let's say that the prevailing charge for a service in the area where Dr. Roberts practices is $20.00 and Dr. Roberts usually charges $18.00 for that service (his customary charge), then if he bills $21.00 for that service (his actual charge), the "reasonable charge" for that service would be the lowest of the three charges—$18.00.

[7]Since a new physician has no "customary" charge, he or she is reimbursed at the 50th percentile of prevailing charges. This means that a new physician is given customary charges no lower than those of established physicians of the same specialty who perform 50 percent of similar services in the area.

On July 1st of each year "reasonable charge" levels are reviewed and updated based upon charges submitted during the preceding calendar year. Usually when Medicare's reasonable charge is lower that a physician's actual charge, it is because the physician has recently raised his or her charge and it has not been in effect long enough to be included in Medicare's annual July review.

Another reason why Medicare's "reasonable charge" may not equal a physician's full charge is the Economic Index. Congress has mandated an Economic Index Limitation be placed on the amount the prevailing charge is allowed to increase from year to year. The Bureau of Labor Statistics updates the Index each year based on appropriate indicators of economic change. The purpose of the Index is to slow down the rate of increase of physicians fees.

Chapter 6

MEDICARE IS A PROGRAM WHICH CAN PAY PHYSICIANS ON AN "ASSIGNED" BASIS, BUT IS NOT A PROGRAM WHICH MAKES THESE PAYMENTS TO THE PHYSICIAN WITHOUT RESTRICTIONS.

Medicare Part B makes payments for physician services in two ways. Payments can be made to the physician (the assignment method) or directly to the patient.

The assignment method can be used only when you and your patient agree to it. In using the assignment method you must agree in advance to accept the reasonable charge Medicare allows as the total fee for your services. You can bill your patient only for the unmet portion of the $60 deductible and 20 percent of the reasonable charge.(Remember, Medicare will pay for 80 percent of the reasonable charge after the $60 deductible has been met.)

You can, of course, accept assignment **only** for covered Medicare services. If a service is not covered, you are free to bill your patient whatever you prefer.

What happens if you think a service is covered, accept assignment, and Medicare denies the claim as not being medically necessary? Who must pay for the noncovered service, the government, the patient or the physician?

In a situation like this the Medicare carrier must decide if either the patient or the physician knew or could have been expected to know that the services would not be covered. Three things can happen:

1) If the patient knew or should have known that Medicare would not consider a service medically necessary, the patient is liable for the charges and may be billed by the physician. (For example, the physician might have told the patient that Medicare might not pay for the service.)

2) If the physician knew or should have known that Medicare would not consider the service medically necessary, the physician is liable and the patient cannot be billed for the noncovered service.

3) If neither the patient or the physician knew or could have known that the services would not be medically necessary, the Medicare program will accept liability and pay the physician.

Don't let the prospect of such a situation occurring deter you from accepting assignment. Each Medicare carrier periodically sends out bulletins outlining new medical procedures that may or may not be covered. As long as you read these bulletins and include medical necessity statements with assigned claims whenever unusual circumstances occur, you shouldn't have any problems.

In situations where you choose not to accept assignment, your patient will apply for reimbursement. Part B Medicare will still pay 80 percent of the reasonable charge above any unmet deductible but there is no Medicare limitation on what you can charge the patient.

For example, let's say Ruby Reynolds, a Medicare patient, has been furnished covered services in a physician's office. The "reasonable charge" for these services is $300. Rather than accepting assignment, Ruby's physician sends her a bill for $340. Ruby has already met the $60 deductible for 1978. What will happen?

The carrier will pay Ruby because it was she who filed a claim for payment. She is paid 80 percent of the reasonable charge. ($240) Since her physician did not accept assignment, Ruby is responsible for the difference between what is paid by Medicare and the physician's bill. In this case the difference is $100.

What would have happened if the physician had accepted assignment?

The carrier would pay the doctor 80 percent of the reasonable charge ($240). The doctor could bill the patient for only the remaining 20 percent of the reasonable charge. ($60)

In this example, if the physician had accepted assignment, he would have received $40 less for his services than had he not accepted assignment. (Assuming, of course, that Ruby is able to pay the additional $40.)

To accept or decline assignment is an important decision that a physician must make for each service he or she renders Medicare patients. You can accept assignment for one service you provide a patient and decline it for another. Once assignment is taken, the decision is final unless both you and the patient request a change. Changes can be made only **before** the Medicare claim is processed.

What does assignment mean to your patient? Assignment is of great financial benefit to most Medicare patients. The average Social Security check in 1977 was $244 per month. Can you imagine living on $244 per month? Unless your patient has put away a sizable retirement nest egg, chances are large medical bills will prove a financial disaster.

Poverty and ill health particularly for the elderly can be a devastating combination. Most senior citizens are plagued by frequent illnesses and accidental injuries and require repeated physician care. Worrying about unpaid bills can make their lives a hopeless misery. You are therefore doing your Medicare patients a great service when you take assignment because then the government can pick up the tab for most medical services they will need.

What does assignment mean to the physician?

Well, for one thing it makes the twin roles of healer of the sick and businessperson more compatible for the physician.

How so?

Well, to be frank, billing Medicare for your services can be more convenient, cheaper and less time consuming than billing your patient. Sure you sacrifice a bit of professional independence when you accept Medicare's "reasonable charge" as your full charge, but, remember, Medicare will **promptly** send you payment for your services.

You won't have to wait until your patients are able to pay. Your bookkeeper won't have to send out dreary monthly notices and meticulously record installments as they trickle in. Many other distasteful aspects of debt collection, angry phone calls, hiring a collection agency, fouled up payment records will be moderated.

You will, in short, have a more efficient office, a better cash-flow (as accountants would say), a happy bookkeeper (an asset in **any** office!) and more cooperative patients, if you accept assignment.

You can also take pride in the fact that you have helped to improve the emotional and financial, as well as the physical well-being of your patients.

Many physicians find assignment to be a useful billing approach. Last year over 53 percent of claims processed by the nation's Medicare carriers were assigned claims.

Chapter 7

MEDICARE IS PAYING MILLIONS OF CLAIMS ROUTINELY IN JUST A FEW DAYS, BUT IT IS NOT A PROGRAM WHICH CAN SUCCESSFULLY PAY CLAIMS WITH INCOMPLETE INFORMATION.

Most Medicare claims are paid promptly without delays or errors. However, since Medicare carriers are organizations composed of human beings and since we homo sapiens are not infallible creatures, delays and mistakes sometimes occur.

Physicians can greatly minimize delays and errors made by Medicare carriers. A well-trained medical assistant staff, for example, is a must for an efficient, smoothly functioning Medicare operation. Most carriers conduct periodic medical assistant staff training classes. Require your staff to attend these sessions, remain knowledgeable about your front office Medicare operation and you should have few Medicare problems. If a problem or misunderstanding should occur, feel free to call your carrier's professional relations staff. They will be happy to help you..

Your first contact with the carrier will be when you apply to participate in Medicare. How do you apply? It's really very simple. Just call or write the carrier's professional relations staff and they will send a questionnaire to complete and some Medicare claim forms.

You will be assigned a carrier control number (some carriers may use your Social Security number), which will identify on the carrier's computer system information about each claim you or your patient submit. A complete file on your actual and customary charges will next be established from which the "reasonable charge" for your future services will be tabulated.

After your control number is set up, you are ready to file Medicare claims. To file a Medicare claim you complete Form 1490 **Request for Medicare Payment** and send it to the carrier as soon as expenses for covered services are incurred.

Under the assignment method of reimbursement, your patient completes Part I of the form 1490 and you complete Part II.[9] If you do not take assignment your patient completes Part I of the Form 1490 and forwards it to the carrier with an itemized bill attached.

An itemized bill is a statement of charges completed by a physician indicating how much has been charged for each covered service.

Certain information must appear on each itemized bill to enable the carrier to process the claim. Your patient's name and claim number must be listed on the itemized bill exactly as they appear on his or her Medicare card. If your patient has misplaced his Medicare card, your local Social Security office will have his Medicare name and number. Each itemized bill should show the date, location and description of each service provided and the diagnosis. The description of each service should be as specific as possible. For example, the value of an office visit should not be increased to include the charge for an injection. The injection should be listed separately showing the name of the drug, the dosage and where applicable, its strength. Descriptions of lab tests, particularly x-rays, should include the exact type and number of tests given. Finally, if there have been unusual circumstances or complications causing a higher than usual charge to be made, this too should appear on the itemized bill. (Unless of course, you feel that the information is too sensitive for your patient to see.)

[9]See Appendix D for a copy of HCFA-1490.

Many carriers use procedure codes to identify physician services which makes itemizing a bill a good deal easier. To find out if procedure codes are used in your area, please contact your carrier's professional relations staff.

Incomplete Form 1490s and insufficiently itemized bills are important causes of delays in processing Medicare claims. It is an excellent idea to have your office staff complete Form 1490s for your patients even when you don't accept assignment. Unassigned Medicare claims are processed much more quickly and accurately if a physician's office staff completes the claim form. In fact, studies show that errors on physician-prepared claims occur only 1/10 as often as errors on patient-prepared claims.

Patients usually wait to pay their doctor bills until **after** they are reimbursed by Medicare. So, your patients will pay their bills **sooner** if you also complete unassigned claims for them. (Quick processing of Medicare claims benefits everyone concerned!)

The extra effort your staff makes to fully complete claim forms and itemized statements is certainly worthwhile. If a claim, be it assigned or unassigned, is filed incorrectly the Medicare carrier will have to call or write your office for more information. Your office staff will then have to waste valuable time poring through patient records to answer the carrier. Doing it right the first time is much easier!

Most carriers should have available a **Guide For Medical Assistants** handbook which describes the best way of filing Medicare claims in most situations your staff will encounter. The carriers also frequently send out newsletters with practical advice on how to get better Medicare

service. For pressing problems, again remember, your carrier's professional relations staff is only a phone call away.

Physicians (on assigned claims) and patients (on unassigned claims) also have the right to appeal payment decisions made by Medicare. If you or your patient disagree with the amount Medicare paid for a medical service, you can ask the carrier for a review. After the review if you or your patient still disagree and the amount in question is $100 or more, you can also request a formal hearing by the carrier.

Chapter 8

MEDICARE IS LIKE OTHER GOVERNMENT PROGRAMS IN THAT IT EXPENDS VAST NUMBERS OF TAX DOLLARS, BUT IT IS NOT A BLANK CHECK.

Medicare is a mammoth federal program. The cost of Medicare to American taxpayers amounted to over 19 billion dollars in 1977. Statistics have an air of unreality about them, but no one can deny that's one whale of a lot of money.

Congress, to keep the Medicare program financially afloat, has included cost containment mechanisms in the law. The Medicare Bureau has the responsibility of seeing that every taxpayer dollar used to administer the program is spent properly.

To prevent excessive Medicare payments from being made, peer review committees have been formed. A peer review committee works through the Medicare carrier in each state and is composed of physicians representing all major specialities of medicine. The peer review committee's function is to examine patterns of physician practice. For example, let's say unscrupulous Dr. Midas decides to get rich via the Medicare program. He exaggerates the severity of his Medicare patients' illnesses and requires them to visit his office much more frequently than necessary. He also extends hospital stays for his patients for incredibly long periods of time.

Can Dr. Midas be stopped? Yes he can; in fact, quite easily. Dr. Midas has a carrier control number which permits the carrier to collect statistical data from Medicare he or his patients submit. These data consist of yearly averages such as the number of visits per patient and the length of hospital stay.

From these data, the carrier's computer may identify Dr. Midas as a candidate for peer review. The carrier's physician consultant staff will then examine Dr. Midas' file and if necessary, refer him to the peer review committee for possible disciplinary action.

Each state has some form of peer review. In some states, county medical society members serve as the peer review committee. In others, members of the state medical association or a group of independent physicians may serve as a peer review group.

The carrier's physician consultant staff carefully scrutinizes the file before considering peer review. Approximately 80 percent of physicians a carrier's computer identifies are not fully examined because evidence in file clearly explains the unusual pattern of practice.

The Office of Program Integrity, Health Financing Administration combats abuse of the Medicare program (i.e. practices that result in unnecessary financial loss to the program). Examples of program abuse are: unnecessary physician visits, assignment agreement violation, unnecessary treatments and separate schedules of charges. (Higher charges for Medicare patients than non-Medicare patients.)

Outright attempts to defraud the Medicare program are handled by the Office of Program Integrity, the HEW Inspector General's Office and the Justice Department. Examples of Medicare fraud are billing for services not rendered, misrepresentation of services rendered, pharmacy kickbacks, deliberate duplicate billings and false or misleading cost reports.

Penalties for abusing or defrauding Medicare can be severe. A fraud conviction can mean a heavy fine and/or a prison sentence. The Secretary of Health, Education and Welfare also has the legal authority to terminate Medicare payments to flagrant abusers of the program.

As you might expect, situations can occur when what appears to be fraud or abuse is just an honest mistake or misunderstanding. Documenting medical necessity in your patient's records is a good way to eliminate misunderstandings. Seeing that your medical assistant staff is well-trained and well-supervised is also excellent "preventive" medicine. Remember—you are ultimately responsible for the accuracy of any Medicare claims or itemized statements sent by your office staff.

Conclusion

We hope this pamphlet will help you in establishing your first medical practice. If you have questions or comments, the phone number and address of the carrier serving your area is listed in Appendix C.

Appendix A

PART A - HOSPITAL INSURANCE

3 major services:

1. Inpatient hospital care
includes:

- Up to 90 days per BENEFIT period (renewable in subsequent benefit periods) plus 60 days LIFETIME RESERVE (nonrenewable) in a PARTICIPATING hospital.
- Psychiatric hospital care (190 days lifetime limit).
- Semiprivate room and board.
- Operating room.
- Special care units.
- Recovery room.
- Drugs, medical supplies and appliances furnished by the hospital.
- Laboratory tests, x-rays and radiological services.
- Rehabilitation services.
- Medical social services.
- EMERGENCY SERVICES (can also be covered in nonparticipating hospitals under certain conditions).

excludes:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury.

Appendix A

excludes:

- Personal comfort items.
- Private duty nurses.
- Physicians services (may be covered under Part B)
- Private room (unless medically necessary)
- Noncovered LEVEL OF CARE

2. Extended care
includes:

- Up to 100 inpatient days in a PARTICIPATING skilled nursing facility (SNF) per BENEFIT PERIOD.
- Semiprivate room and board.
- Regular nursing services.
- Drugs, medical supplies and appliances furnished by the SNF.
- Therapy (physical, occupational, speech).
- Medical social services.

NOTE: Admission to the SNF must follow, within 14 days, of a qualifying hospital stay of at least 3 consecutive days (the 14-day requirement may be extended under certain conditions).

Appendix A

Patient must:

- Be admitted for further treatment of a condition treated in the hospital.

- Require skilled nursing care or other skilled rehabilitation services on a daily basis.

- which -

as a practical matter can only be provided in the SNF on an inpatient basis.

excludes:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury.
- Personal comfort items.
- Private duty nurses.
- Physicians services (may be covered under Part B).
- Private room (unless medically necessary).
- Noncovered LEVEL OF CARE

3. Home Health Services
   Covered only if patient:

- Confined to home.
- Under care of physician.
- Under home health plan established by physician with 14 days after discharge from hospital or SNF.

Appendix A

- Needs intermittent or part-time skilled nursing care or physical or speech therapy for condition for which he received inpatient hospital or extended care services.

- Is provided services within year following most recent discharge from 3-day hospital or covered SNF stay, whichever is later.

include:

- Up to 100 visits from a PARTICIPATING home health agency (HHA) after start of one BENEFIT PERIOD and before start of next.

- Part-time skilled nursing care.

- Therapy (physical, occupational, speech).

- Part-time services of home health aides.

- Medical supplies and appliances furnished by the HHA.

- Medical Social Services.

exclude:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury.

- Full-time nursing care.

- Drugs and biologicals.

Appendix A

- Personal comfort items.
- Meals delivered to the home.
- Homemaker services.
- Physicians' services (may be covered under Part B).

Appendix B

PART B - MEDICAL INSURANCE

Includes:

- Physicians' services (and services and supplies furnished incident to a physician's professional service).

- Outpatient hospital services:

  - incident to physicians' services
  - diagnosis and therapeutic services provided by a PARTICIPATING hospital (for EMERGENCY SERVICES may sometimes be by a nonparticipating hospital).

- Diagnostic tests
  - x-ray
  - lab tests

- Therapy
  - x-ray
  - radium
  - radioactive isotope

- limited chiropractic services.

- Other medical supplies such as
  - splints
  - casts
  - devices used for reduction of fractures and dislocations

- Durable medical equipment for use in patient's home (rental or purchase) including home dialysis equipment and supplies.

Appendix B

- Chronic renal disease facility care by approved suppliers of maintenance dialysis services.

- Certain ambulance services.

- Prosthetic devices replacing all or part of an internal body organ (including prosthetic eyeglasses and contact lenses which replace the lens of the eye removed during cataract surgery).

- Braces for arm, leg, back, neck.

- Artificial arms, legs, eyes.

- Home health services - up to 100 visits in a calendar year, in addition to Part A visits (same requirements as Part A except prior hospitalization not required).

- Outpatient physical therapy and speech pathology by a PARTICIPATING hospital, SNF, HHA, or approved clinic, rehabilitation agency or public health agency.

- Coverage of services of independently practicing physical therapists (up to $100 of REASONABLE CHARGES per calendar year).

Excludes:

- Items and services not medically necessary.

- Routine physical check-ups.

- Hearing aids, eyeglasses and examinations for fitting them (exception: see prosthetic devices above).

PART B - MEDICAL INSURANCE

excludes:

- Immunizations (except where immediate risk of infection).
- Cosmetic surgery.
- Dental services (for example: treatment, filling, removal or replacement of teeth).
- Routine and certain other foot care.
- Orthopedic shoes (unless part of a leg brace) and other supportive devices for the feet.
- Prescription drugs.

Appendix C

MEDICARE WORKS FOR PHYSICIANS, PATIENTS AND THE GOVERNMENT MOST OF THE TIME. SHOULD A PROBLEM OCCUR, THE FOLLOWING OFFICES MAY PROVE HELPFUL.

NATIONAL POLICY
Department of Health, Education and Welfare
Health Care Financing Administration
Medicare Bureau
Professional Relations Staff
1-N-4 East Low Rise
6401 Security Boulevard
Baltimore, MD 21235

REGIONAL PROGRAM DIRECTION
Department of Health, Education and Welfare
Health Care Financing Administration
Medicare Bureau
101 Marietta Tower
Suite 702
Atlanta, GA 30323

PART B CARRIERS

ALABAMA
Blue Cross and Blue Shield of Alabama
930 South 20th Street
Birmingham, AL 35298

Professional Relations: (205) 328-3410, Ext. 291, 298

FLORIDA
Blue Shield of Florida
Post Office Box 1798
Jacksonville, FL 32201

Professional Relations: (904) 791-6373

Appendix C

Group Health Incorporated*
1320 South Dixie Highway
Coral Gables, FL 33146

Professional Relations: (305) 442-1500
*Dade and Monroe Counties only

GEORGIA
The Prudential Insurance
Company of America
Post Office Box 98157
Briarcliff Station
Atlanta, GA 30359

Professional Relations: (404) 325-5614

KENTUCKY
Metropolitan Life Insurance Co.
1218 Harrodsburg Road
Lexington, KY 40504

Professional Relations: (606) 233-1436

MISSISSIPPI
Travelers Insurance Company
4795 Interstate Highway 55, North
Post Office Box 22545
Jackson, MS 39205

Professional Relations: (601) 982-9411

Appendix C

NORTH CAROLINA
The Prudential Insurance
Company of America
Medicare B
Post Office Box 2126
High Point, NC 27261

Professional Relations: (919) 885-8171

SOUTH CAROLINA
Blue Cross and Blue Shield
of South Carolina
Medicare B, Drawer F,
Forest Acres Branch
Columbia, SC 29260

Professional Relations: (803) 788-3860

TENNESSEE
The Equitable Life Assurance
Society of the United States
Post Office Box 1465
Nashville, TN 37202

Professional Relations: (615) 244-5600 Ext. 218

Appendix D

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

Form Approved OMB No. 72-R0730

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number (Include all letters) ☐ Male ☐ Female

3 Patient's mailing address City, State, ZIP code Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)

Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency (including FEHB), show below.

Name and address of organization or agency | Policy or Identification Number

Note: If you Do Not want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient (See instructions on reverse where patient is unable to sign) Date signed

SIGN HERE

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given — Procedure Code	D. Nature of illness or injury requiring services or supplies (diagnosis)	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No.

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill ☐ I accept assignment (See reverse) ☐ I do not accept assignment.

13 Show name and address of person or facility which furnished service (if other than your own office or patient's home)

14 Signature of physician or supplier (A physician's signature certifies that a physician's services were personally rendered by the physician or under the physician's personal direction) Date signed

*O—Doctor's Office *L—Independent Laboratory *H—Patient's Home (If portable X-ray services, identify the supplier) *I—Inpatient Hospital SNF—Skilled Nursing Facility OH—Outpatient Hospital OL—Other Locations *NH—Nursing Home

FORM HCFA-1490. (11-75)

Department of Health, Education, and Welfare
Social Security Administration

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